



# United States Department of the Interior

## BUREAU OF INDIAN AFFAIRS

Washington, DC

1849 C Street, NW, MS-4513-MIB

Washington, DC 20240

(202) 513-7640

IN REPLY REFER TO:

**INTERVIEW DATE:** \_\_\_\_\_

## ***APPLICATION FOR FINANCIAL ASSISTANCE AND SOCIAL SERVICES INSTRUCTIONS***

Any individual or family may apply for Bureau of Indian Affairs (BIA) Financial Assistance and Social Services by completing the application process with the assistance of the Social Services worker and providing the following required information: proof of tribal membership; proof of residency; proof of income and resources. Failing to provide this information may result in denial of Financial Assistance and Social Services.

### **DIRECTIONS FOR COMPLETING "APPLICATION FOR FINANCIAL ASSISTANCE AND SOCIAL SERVICES" FORM**

Please fill in ***your*** NAME/TRIBE/PHYSICAL ADDRESS/PHONE NUMBER/MAILING ADDRESS (if different from physical address) or provide directions on how to get to your home. Please also respond to the two questions.

#### **Section I: FAMILY PROFILE OF HEAD OF HOUSEHOLD MEMBERS APPLYING**

Under Family Profile, fill in the following information to the best of your ability. First, start with yourself. Please fill in your name (Last, First, Middle), Date of Birth (mm/dd/yyyy), Sex (M/F), your marital status, the highest education level received, Social Security Number, and finally your Tribal Enrollment Number. Next, complete the names of the total members of the household starting with your spouse and then children in descending order of age. For each member list the birth date, sex, and relation to the head of household, marital status, highest education received, Social Security Number, and Tribal Enrollment number. If you are living in a household with more than one (1) family, list the family members that fall under your household.

#### **Section II: TYPES OF FINANCIAL ASSISTANCE AND SOCIAL SERVICES**

Put a check mark in the boxes for the services you are applying. This will assist your Social Services worker in determining which portions of the application you will need to complete.

#### **Section III: EARNED & UNEARNED INCOME**

All income, including earned and unearned income, for yourself and any other person in your household, is to be listed on the application. You are required to provide proof of income.

##### *Earned Income*

is cash or any in-kind payment earned in the form of wages, salary, commissions, or profit by an employee or self-employed individual. This includes one-time payments for ongoing activities such as sale of crops or sale of art-work. Self-employed individuals must report profits from business enterprises (gross receipts minus business expenses included in the production of goods or services). Business expenses do not include depreciation, personal transportation costs, capital equipment purchases or principal payments on loans for capital assets or durable goods. (25 CFR §20.308)

##### *Unearned Income*

includes but is not limited to; interest, royalties, gaming income or other per capita distribution not excluded by federal statute, rental property, cash contributions such as child support or alimony, gaming winnings, retirement benefits, annuities, veteran's disability, unemployment benefits, and tax refunds. Other types of unearned income include financial assistance from government agencies, income from sale of trust land or other real or personal property set aside for investment in trust land that has not been reinvested in trust land or a sale of a primary residence that has not been reinvested in a primary residence at the end of one year from the date the income was received, and in-kind contributions providing free shelter up to the 25% of the amount for shelter included in the state standard. (25 CFR §20.309).

Under Section II and Section III please complete questions 1-4 to the very best of your ability based on the information provided above. If you are unsure of the question please ask your Social Services worker for assistance or clarification.

**Section IV: STATEMENT OF COOPERATION**

The Statement of Cooperation is a confirmation of your understanding of the provisions of the Federal Law governing fraud, and you agree to supply information regarding resources and income and to notify the agency of any change in your living situation. Also you must sign the Release of Information authorizing the Social Services Program to obtain and/or exchange information necessary to establish eligibility for Financial Assistance and Social Services.

***IF YOU NEED CLARIFICATION OR HAVE ANY QUESTIONS, PLEASE ASK YOUR SOCIAL SERVICES WORKER***

**U.S. Department of the Interior  
Bureau of Indian Affairs  
Division of Human Services**

Date of Application: \_\_\_\_\_

Date of Interview: \_\_\_\_\_

**Decision:**

Approved; Date: \_\_\_\_\_ to \_\_\_\_\_: \_\_\_\_\_  
Initials

Denied; Date: \_\_\_\_\_: \_\_\_\_\_  
Initials

Reason for Denial: \_\_\_\_\_

Date of Redetermination \_\_\_\_\_ / \_\_\_\_\_

**APPLICATION for  
FINANCIAL ASSISTANCE and SOCIAL SERVICES**

**GRAY SHADED AREAS ARE FOR AGENCY USE ONLY.**

Name: \_\_\_\_\_ Tribe: \_\_\_\_\_

Also known as: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Cell/ MSG Number: \_\_\_\_\_

Provide directions on how to get to your home: \_\_\_\_\_

1. Reason for applying for Financial Assistance and Social Services?

2. What type of income have you been living on for the last three (3) months?

**Section I: FAMILY PROFILE OF HEAD OF HOUSEHOLD MEMBERS APPLYING (25 CFR §20.308)**

**Fill in all required blanks for everyone who lives with you, either permanently or temporarily. You must list yourself first, then your spouse and children, then other adults and children. Place an asterisk (\*) to the left of each person not included in payment.**

Members of Household (Last, First, Middle)	Date of Birth			Sex (M/F)	Relation to Head of Household	Marital Status (Married, Single, Widowed, Divorced, Common Law, Separated)	Highest Grade/ Degree Completed	Social Security Number	Verified	Tribal Enrollment Number	Verified
	Month	Day	Year								
1.					SELF						
2.											
3.											
4.											
5.											
6.											
7.											
8.											

**Section II: TYPES OF FINANCIAL ASSISTANCE AND SOCIAL SERVICES** (Check type of Assistance or Services applying for)

[Items with an asterisk (\*) require BIA Line Officer Approval & Signature; Cost-Sharing for Foster Care or Adoption Subsidy requires BIA Line Officer Approval & Signature]

<p><b>A.</b> <input type="checkbox"/> General Assistance</p> <p><b>D.</b> <input type="checkbox"/> Burial Assistance</p> <p><b>E.</b> <input type="checkbox"/> Emergency Assistance</p> <p><b>G.</b> <input type="checkbox"/> Information &amp; Referral Only</p>	<p><b>B. Child Assistance</b></p> <p>* <input type="checkbox"/> Foster Care</p> <p>* <input type="checkbox"/> Residential Care</p> <p>* <input type="checkbox"/> Adoption Subsidy</p> <p>* <input type="checkbox"/> Guardianship Subsidy</p> <p><input type="checkbox"/> Special Needs</p> <p>* <input type="checkbox"/> Homemakers Services</p>	<p><b>C. Adult Care Assistance</b></p> <p>* <input type="checkbox"/> Homemakers Services</p> <p>* <input type="checkbox"/> Residential Care/ Group Home</p>	<p><b>F. Services-Only</b></p> <p><input type="checkbox"/> Child Protection</p> <p><input type="checkbox"/> Adult Protection</p> <p><input type="checkbox"/> Child &amp; Family Services</p> <p><input type="checkbox"/> IIM Services</p>
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**Section III. EARNED INCOME & UNEARNED INCOME (25 CFR §20.308-§20.310)**

Is anyone in the household currently working or have they worked in the past 30 days  Yes  No  
 If yes, identify Household Member(s) who are working and their earnings:  
 Household Member # 1 \_\_\_\_\_ Amount \$: \_\_\_\_\_  
 Household Member # 2 \_\_\_\_\_ Amount \$: \_\_\_\_\_  
 Household Member # 3 \_\_\_\_\_ Amount \$: \_\_\_\_\_

Do you expect to receive or are receiving any of the following listed below:  Yes  No  
 (If yes, put a check mark in the box in front of all unearned income (not from employment) received by any household members, (see box below; use additional space for further explanation.)

Earned Income		Unearned Income	
<input type="checkbox"/> Wages/ Salary	Amount: \$ _____	<input type="checkbox"/> Supplemental Security Income (SSI)	Amount: \$ _____
<input type="checkbox"/> Alimony/ Child Support	Amount: \$ _____	<input type="checkbox"/> TANF	Amount: \$ _____
<input type="checkbox"/> Gifts/ Contributions	Amount: \$ _____	<input type="checkbox"/> Food Stamps	Amount: \$ _____
<input type="checkbox"/> Income Tax Refund (Federal/State)	Amount: \$ _____	<input type="checkbox"/> Commodities	
<input type="checkbox"/> Insurance Settlement (Auto Accident, etc)	Amount: \$ _____	<input type="checkbox"/> Foster Care Payments	Amount: \$ _____
<input type="checkbox"/> Interest/ Dividends (Bank Accounts) Other (list): _____	Amount: \$ _____	<input type="checkbox"/> Other (list) (Example: Carl Perkins P.L. 105-332)	Amount: \$ _____
<input type="checkbox"/> Lease Income (list) _____	Amount: \$ _____	<input type="checkbox"/> Other (list) (Example: Alaska Native Corporation Dividend)	Amount: \$ _____
<input type="checkbox"/> Lottery/ Gaming Income (cash winnings)	Amount: \$ _____	Explain the Amount Approved and/or Disapproved- need to specify gross and net earnings. (Social Service Worker Section)	
<input type="checkbox"/> Retirement Benefits/ Pensions	Amount: \$ _____		
<input type="checkbox"/> Royalties	Amount: \$ _____		
<input type="checkbox"/> Tribal Per Capita Payments	Amount: \$ _____		
<input type="checkbox"/> Social Security/ Survivor/ Disability Benefits	Amount: \$ _____		
<input type="checkbox"/> Unemployment Benefits	Amount: \$ _____		
<input type="checkbox"/> Veteran's Benefits/ Payments	Amount: \$ _____		
<input type="checkbox"/> Worker's Compensation Benefits	Amount: \$ _____		
<input type="checkbox"/> Farm/ Ranch Income	Amount: \$ _____		

Have you applied for TANF?  YES  NO Date: \_\_\_\_\_  
 Have you been terminated from TANF past 90 days?  YES  NO  
 Are you eligible to reapply for TANF?  YES  NO  
 Have you applied for other Resources/ Programs?  YES  NO Date: \_\_\_\_\_

**Section IV. STATEMENT OF COOPERATION**

I/We apply for financial assistance/ services for the listed members of my (our) household who are in need.  
 I/We have received a copy of and have had explained to us, and understand the provisions of Federal Law governing fraud.

Under 18 U.S.C. §1001, the Federal Law concerning fraud states: "Whoever, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes or uses any false writing or documents, knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than \$10,000 or imprisoned not more than five years or both."

I (We) agree to supply information regarding resources and income and to notify the agency of any changes in my (our) situation. Release of Information: Human Services is authorized to obtain/exchange information necessary to establish eligibility for assistance. I (We) have read, or had explained to me/us, the provision of our protection under the Paperwork Reduction Act and the Privacy Act.

**Please check:**  Read, Understood & Signed the Fraud Statement  
 Read, Understood & Signed the Paperwork Reduction Act  
 Read, Understood & Signed Release of Information & Privacy Act/FOIA

\_\_\_\_\_  
Date Signature of Applicant #1 \_\_\_\_\_ Date Signature of Applicant #2 \_\_\_\_\_  
 \_\_\_\_\_  
Date Social Services Worker Signature \_\_\_\_\_ Date BIA Line Officer (If Applicable) \_\_\_\_\_

**FOR HUMAN SERVICES WORKER USE ONLY- INTERVIEW SECTION (Pages 5-18)**

Not applicable

**A. GENERAL ASSISTANCE (25 C.F.R. §20.300 – §20.323)**

<input type="checkbox"/> Employable	<input type="checkbox"/> Unemployable (25 CFR §20.315)	<input type="checkbox"/> Pending Public Assistance
	<input type="checkbox"/> (a) Younger than 16 years-old	Date Applied: _____
	<input type="checkbox"/> (b) A full-time student under the age of 19	Date Verified by Worker: _____
	<input type="checkbox"/> (c) Student; P.L. 100-297	
	<input type="checkbox"/> (d) Medical Exemption	
	<input type="checkbox"/> (e) Incapacitated Person; not yet receiving SSI	
	<input type="checkbox"/> (f) A caretaker of a person with a Mental/ Physical impairment	
	<input type="checkbox"/> (g) Parent with Child under the age of 6	
	<input type="checkbox"/> (h) Distance Related	
____ Miles    ____ Time    ____ Mode of Transport		

**Application for Assistance**

Yes	No	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	---	Written & Signed Application for Assistance
<input type="checkbox"/>	<input type="checkbox"/>	---	Timely Approval Notice Provided
<input type="checkbox"/>	<input type="checkbox"/>	---	Timely Denial Notice Provided
<input type="checkbox"/>	<input type="checkbox"/>	---	Hearing Rights Provided
<input type="checkbox"/>	<input type="checkbox"/>	---	Fraud Statement Provided

**Eligibility Factors**

Yes	No	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	---	Member of a Federally Recognized Indian Tribe or Alaska Native Village
<input type="checkbox"/>	<input type="checkbox"/>	---	Reside in a Designated Service Area or Alaska Native Village
<input type="checkbox"/>	<input type="checkbox"/>	---	Does not have Sufficient Resources
<input type="checkbox"/>	<input type="checkbox"/>	---	Concurrent Application to other Agencies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ISP Developed and Signed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assess Applicant Employability
<input type="checkbox"/>	<input type="checkbox"/>	---	Not Receiving Public Assistance (SSI/ TANF)

**Eligibility Re-Determination**

Yes	No	N/A		Yes	No	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Monthly Job Search Documented
<input type="checkbox"/>	<input type="checkbox"/>	---	Review & Update Eligibility (3 or 6 months)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suspension/ Termination (if applicable)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Signed ISP/Progress update every 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Job Search Exemption documented
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Recipient complying with ISP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Monitor Recipients training or work related activities
<input type="checkbox"/>	<input type="checkbox"/>	---	Home Visit to verify Income, HH Composition & Residency				

**Referral(s) to other Resources Services: Check programs to which the applicant is being referred:**

<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/> Tribal Programs:
<input type="checkbox"/> Indian Health Services (IHS)	Identify: _____
<input type="checkbox"/> Educational/ GED/ Vocational	<input type="checkbox"/> Social Security Administration (SSA)
<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> Housing Programs (HUD)
<input type="checkbox"/> Alcohol and Substance Abuse (ASA)	<input type="checkbox"/> State/ County Programs
<input type="checkbox"/> Medicare	<input type="checkbox"/> Veteran's Administration (VA)
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other:
<input type="checkbox"/> Employment Program	Identify: _____
	<input type="checkbox"/> No Referral was made

**BUDGET CALCULATION (25 CFR §20.311-§20.313)**

**Household Size:** Adults: \_\_\_\_\_ Children: \_\_\_\_\_ **TOTAL HOUSEHOLD SIZE:** \_\_\_\_\_

<b>1. Monthly State Standard</b>	\$ _____
2. Monthly Deductions	\$ _____
3. Monthly Earned Income	\$ _____
4. Monthly Unearned Income	\$ _____
5. Monthly Liquid Assets* Available	\$ _____
6. Total Monthly Income	\$ _____
<b>7. Total Monthly Countable Income</b>	\$ _____
<b>8. APPROVED AMOUNT</b>	\$ _____

State Standard:
Deductions:
Earned Income:
Unearned Income:
Liquid Assets*:
<b>What are your monthly expenses?</b>
Shelter/ Rent: \$ _____
Utilities: \$ _____
Food: \$ _____
Clothing: \$ _____
<b>TOTAL MONTHLY EXPENSES: \$ _____</b>

\*Liquid Assets includes properties in the form of cash or other financial instruments which can be connected to cash, such as savings or checking accounts, promissory notes, mortgages and similar properties and retirement annuities.

Additional Comments or Notes

Application Approved       Application Disapproved

\_\_\_\_\_  
Date of Approval

\_\_\_\_\_  
Date of Disapproval

\_\_\_\_\_  
Social Services Worker Signature

\_\_\_\_\_  
Date of Signature

Not applicable

**B. CHILD ASSISTANCE**  
**(25 C.F.R. §20.500 - §20.515)**

Name of Child: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Tribe: \_\_\_\_\_ Amount of Assistance: \$ \_\_\_\_\_

Expected Length of Placement: \_\_\_\_\_

Current Placement Address: \_\_\_\_\_

Current Placement Telephone: \_\_\_\_\_

**Reason for Placement (Check all that apply):**

Abandonment  Parents with ASA Problems  Neglect  Physical Abuse  Sexual Abuse

Other: \_\_\_\_\_

**TYPE OF ASSISTANCE**

- Foster Care
- Residential Care
- Homemaker
- Adoption Subsidy
- Guardianship Subsidy
- Service-Only
  - Title IV-E
  - SSI
  - Independent Living
- Other Assistance (e.g. Special Needs)

**Outcome of Services:**

**Permanency Plans (developed within 12-months):**

**Name of Parents or Guardians:**

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Whereabouts: \_\_\_\_\_

Whereabouts: \_\_\_\_\_

Address (if known): \_\_\_\_\_

Address (if known): \_\_\_\_\_

Income: \_\_\_\_\_

Income: \_\_\_\_\_

Income Verification Provided (Pay Stub, Written Statement, etc.)

Income Verification Provided (Pay Stub, Written Statement, etc.)

**Application for Assistance**

Yes No N/A

--- Written & Signed Application for Assistance (Parents or Legal Guardian Must Sign Application)

--- Timely Approval Notice Provided

--- Timely Denial Notice Provided

--- Hearing Rights Provided

--- Fraud Statement Provided

NOTE: Bureau Line Office Must Approve/Disapprove Applications for Homemaker Services, Adoption & Guardianship Subsidy, and Cost Share Placement

**Eligibility Factors**

Yes No N/A

--- Enrolled Member of a Federally Recognized Indian Tribe or Alaskan Native Village

--- Reside in Designated Service Area or Alaska Native Village

Not eligible for Other Federal/State/Tribal Assistance

Parents Statement that they are unable to provide Care/Supervision

Family/ Social Service Assessment Supports Parent's Inability; complete assessment in 30 days; update in 60 days/ 6 months

- Child's Income is Used to off-set Cost of Care
- Placement Beyond 30-days is supported by a Court Order
- Parents with Income Contributed Toward the Cost of Care

**Conditions of Payment**

**Using Child Assistance**  Not applicable

Yes No N/A

- Payment is Based on State Established Rate for Room & Board Only
- Placement Includes Agreement with Other Agencies Regarding Cost & Service(s): (25 C.F.R. §20.502(b))
  - a) Education
  - b) Mental Health
  - c) Alcohol & Substance Abuse
- Payment was NOT Made to a Psychiatric Facility
- Payment was NOT Made to an Alcohol and Substance Abuse Treatment Center
- Parental Agreement for Payment is in the Case Plan and Followed: Case Plan was Developed, Signed & Implemented
- Special Need Cost is Justified
- Approved Payment is Less than the Child's Non-Federal Exempted Income
- The Provider Possesses a Current Tribal Certification/ Licensure or are State Licensed
- Effort was Made to Secure Child Support
- Monthly Visitation of Social Worker to Child in Placement
- The results of the Background Check are in the File (P.L. 101-630 & Adam Walsh Act)
- Terms of Payment/ Monthly Invoices show the Daily Rate, Amount Deducted & Amount Paid
- Supervisor reviewed Case Plan every 90-Days

**For Adoption & Guardianship Subsidy (25 C.F.R. §20.503)**

Yes No N/A

- Long-Term BIA/Tribal Social Services Foster Care Child
- Child is Seventeen (17) years of Age or Younger
- Child is not Eligible for Other State/Federal Resource, e.g. TANF, IV-E (Denial Letter on File)
- Payment does not Exceed State Rate (less Child's Non-Exempted Income)
- Provider is Tribally Certified or Licensed, or State Licensed and has a Home-Study
- Payment Subsidy Approved Annually by a Bureau Line Officer (Superintendent)
- Child has been in Foster Care prior to Approval to the Subsidy

**To a Residential Care Facility**

Yes No N/A

- Annual Evaluation of the Use of the Facility was Completed
- Provide Quarterly Progress Reports- (Best Practice)
- Service Follows Signed Case Plans for Child and their Family
- Monthly Visitation to Child in Placement
- Efforts to Preserve or Reunite the Family is Documented
- The Facility is Licensed by the Appropriate Agency
- The Payment DOES NOT exceed County/ State Established Rates for Room & Board

**For Homemaker (25 C.F.R. §20.504)**

Yes No N/A

- Service DID NOT Exceed 3 months; and IS NOT a 24 Hour Service
- Family Assessment Supports Need for Homemaker Service
- Number of Hours is Documented; and Payment is According to State Rate
- Focus of Service is on Training Others/ Non-Medical Supportive Service
- Documented Service Follows Signed Case Plans for Child and the Family
- Child & Family is Served Concurrently



**For Foster Care**

Yes No N/A

- Foster Parent Received Training
- Annual Evaluation of Home was Completed
- Efforts to Preserve or Reunite the Family is Documented
- Family Assessment Completed Within 30 Days of Placement; Updated Within 60 days
- Monthly Visit to Monitor Progress of Child and Family
- The Foster Home is Licensed or Certified
- Payment is According to the County/ State Established Rate

**Family & Child was Referred to Appropriate Agency For:**

Yes No N/A

- Mental Health Services
- Alcohol & Substance Abuse
- Education Service

Yes No N/A

- Therapy
- Juvenile Services
- Other:

**Parental Consent was Obtained for:**

Yes No N/A

- Emergency Transportation
- Medical Care
- School Attendance

**The Record Contains Copies of: (25 C.F.R. §20.506(a-1))**

Yes No N/A

- (a) Tribal Enrollment Verification;
- (b) Written Case Plan;
- (c) Information on Child's Health Status and School Records (e.g., immunization records and medications);
- (d) Parent Consent for Emergency Medical Care, School and Transportation;
- (e) A Signed Plan for Payment;
- (f) Copy of the Certification/ Licensure of the Foster Home;
- (g) Current Photo of the Child;
- (h) Copy of the Social Security Card, Birth Certificate, Medicaid Card and Current Court Order;
- (i) Discuss Child's Needs with Parent's/ Foster Parent's / Residential Care & Placement Agency;
- (k) Document Monthly Visits & Progress;
- (l) All prior Placement(s) are Listed

**Court Responsibilities**

Yes No N/A

- Court Reviews Cases Every 6 months
- Court has Permanency Hearings Every 12 Months
- Court Orders are NOT prescriptive (25 C.F.R. §20.510)

**Payment**

Amount of Parent Contributions \$ \_\_\_\_\_ How often are payments allocated? \_\_\_\_\_

Amount of Child Assistance \$ \_\_\_\_\_ How often are payments allocated? \_\_\_\_\_

Name of Payee (Institution): \_\_\_\_\_

Additional Comments or Notes

Application Approved       Application Disapproved

\_\_\_\_\_  
Date of Approval

\_\_\_\_\_  
Date of Disapproval

\_\_\_\_\_  
Social Services Worker Signature

\_\_\_\_\_  
Date of Signature





















